1.0 Description of the Service

An Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) (42 CFR 435.1009) is an institution, or distinct part thereof, that:

1. Functions primarily for the diagnosis, treatment or rehabilitation of the mentally retarded or persons with a related condition; and
2. Provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his or her greatest ability. (CMS website, ICF/MR glossary; http://www.gpoaccess.gov.cfr/index.html)

2.0 Eligible Recipients

2.1 General Provisions

1. Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.
2. Medicaid recipients who are Medicaid-certified at the ICF/MR level of care are eligible to receive ICF/MR services.
3. Eligibility for ICF/MR level of care is based on each individual's need for ICF/MR services and not merely on the diagnosis.

2.2 Special Provisions

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that provides recipients under the age of 21 with medically necessary health care to correct or ameliorate a defect, physical or mental illness or a condition identified through a screening examination. While there is no requirement that the service, product or procedure be included in the State Medicaid Plan, it must be listed in the federal law at 42 U.S.C. § 1396d(a). Service limitations on scope, amount or frequency described in this coverage policy do not apply if the product, service or procedure is medically necessary.

The Division of Medical Assistance's policy instructions pertaining to EPSDT are available online at http://www.dhhs.state.nc.us/dma/prov.htm.

3.0 When the Service is Covered

3.1 General Criteria

1. Medicaid reimburses for services that are determined medically necessary; **and**
2. The services must be individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs; **and**
3. Services must be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; **and**
4. Services are furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker or the provider; **and**

5. Reimbursement for formal educational or vocational services is allowed only for those services documented as active treatment.
6. Active treatment is directed toward the following:
   a. The acquisition of behaviors necessary for a recipient to function with as much self-determination and independence as possible,
   b. The prevention or deceleration of regression or loss current optimal functional status.

Note: Active treatment is a continuous program that includes aggressive, consistent implementation of specialized and generic training, treatment, health services, and related services described in 42 CFR 483.

3.2 ICF/MR Level of Care Criteria

In order to be Medicaid-certified at an ICF/MR level of care, an individual must meet the following criteria:

1. Require active treatment necessitating the ICF/MR level of care; **and**
2. Have a diagnosis of mental retardation, Intelligence Quotient (IQ) test results indicating mental retardation, or a condition that is closely related to mental retardation.
   a. Mental retardation is a disability characterized by significant limitations both in general intellectual function resulting in, or associated with, deficits or impairments in adaptive behavior. The disability manifests before age 18.
   b. Persons with closely related conditions refers to individuals who have a severe, chronic disability that meets **ALL** of the following conditions:
      i. is attributable to:
         (a) Cerebral palsy, epilepsy; **or**
         (b) Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons; **and**;
      ii. The related condition manifested before age 22; **and**
      iii. Is likely to continue indefinitely; **and**
      iv. Have mental retardation or a related condition resulting in substantial functional limitations in three or more of the following major life activity areas (see **Attachment B**):
         (a) Self-Care (ability to take care of basic life needs for food, hygiene, and appearance)
         (b) Understanding and use of language (ability to both understand others and to express ideas or information to others either verbally or non-verbally)
         (c) Learning (ability to acquire new behaviors, perceptions and information, and to apply experiences to new situations)
         (d) Mobility (ambulatory, semi-ambulatory, non-ambulatory)
         (e) Self-direction (managing one's social and personal life and ability to make decisions necessary to protect one's life)

(f) Capacity for independent living (age-appropriate ability to live without extraordinary assistance).

Note: Reports by physicians, psychologists, and other appropriate disciplines are evaluated to determine whether an individual has a substantial functional limitation in a major life activity.

4.0 When the Service is Not Covered

4.1 General Criteria

1. Recipient does not meet the eligibility requirements listed in **Section 2.0.**
2. Recipient does not meet medical necessity criteria listed in **Section 3.0.**
3. Medicaid does not reimburse for services that duplicate another provider's service.
5. Medicaid does not reimburse for services that are experiential, investigational or part of a clinical trial.
6. With the exception of active treatment services, Medicaid payments to an ICF/MR do not include reimbursement for formal educational services or for vocational services.
7. Active treatment does not include services to maintain generally independent recipients who are able to function with little supervision or in the absence of a continuous active treatment program

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

Prior approval (PA) for ICF/MR level of care is required. To obtain PA an MR2 form (signed and dated by the physician) and supporting documentation (see **Section 2.2**) must be sent directly to the agency that performs PA review and approval. The case manager must also sign the MR2 form. Prior approval is required in the following circumstances:

1. When there is an admission to an ICF/MR
2. When the utilization review committee recommends change in the level of care.
3. When residents seek Title XIX assistance in an ICF/MR and were previously private pay or insured by a third party carrier.
4. When a resident is discharged from an ICF/MR to a lower level of care or to his own home, and later re-applies for ICF/MR level of care, prior approval is required.
5. When a Medicaid recipient's benefits are terminated for 90 days or more before reinstatement even though the individual remains in the same facility.

5.2 Individual Program Plan

1. The recipient's interdisciplinary team must prepare an Individual Program Plan (IPP) which includes opportunities for individual choice and self-management (see **Section 7.4**). The IPP identifies the following:
   a. Discrete, measurable, criteria-based objectives the individual is to achieve;
   b. Specific individualized program of specialized and generic strategies, supports and techniques to be employed.

2. The IPP must be directed toward the acquisition of the following:
   a. Behaviors necessary for the individual to function with as much self-determination and independence as possible; **and**
   b. Prevention or deceleration of regression or loss of current optimal functional status.

5.3 Reimbursement of Services

Because Medicaid reimburses only for services documented as active treatment, providers must differentiate educational goals from other goals in the recipient's IPP. Providers must also describe those services that are considered part of active treatment.

5.4 Allowable Costs

Personal laundry and hygiene items can be reported as an allowable cost to the ICF/MR. The following items are included in the Medicaid per-diem rate and cannot be charged to the resident's personal funds:

Haircuts and shampooing	Moisturizing lotion
Bath soap	Nail care
Brush	Personal laundry
Comb	Razors
Cotton balls	Sanitary napkins and related supplies
Cotton swabs	Shampoo
Dental floss	Shaving cream
Dental Adhesive	Specialized cleansing agent (skin)
Denture cleaner	Tissues
Deodorant	Toothbrush
Disinfecting soaps	Toothpaste
Hair conditioner	Towels
Hospital gowns	Washcloths
Dental mouth rinses (non-prescription)	

5.5 Hair Care Services

1. The ICF/MR is responsible for providing residents' basic hygiene, including hair care. Basic hair care services (for example, wash, cut, shampoo, conditioner) furnished to residents by facility personnel, barber, or beauticians are allowable costs for reimbursement and are included in the facility's per-diem rate.
2. Residents can be billed for hair care in excess of basic hair care (such as color, style, or permanent wave) because these services are non-allowable costs for Medicaid payment.

5.6 Prescription Drugs

1. A 34-day grace period is available for obtaining prescription drug prior authorization (PA) for Medicaid recipients in ICFs/MR. A single 34-day grace period per prescription can be granted and applies to recipients already residing in these facilities as well as newly admitted recipients.
2. The grace period allows additional time to gather the medical information necessary to request PA from the contractor administering the prescription drug PA program. If the contractor determines that the request does not meet the PA criteria, the prescriber may submit a request for exemption.

5.7 Therapeutic Leave

5.7.1 Each Medicaid-eligible recipient in an ICF/MR is entitled to take up to 60 days of therapeutic leave in any calendar year. The leave must be for therapeutic purposes only and must be ordered by the resident's attending physician. The necessity for the leave must be documented in the resident's plan of care and therapeutic justification for each instance of leave must be documented in the recipient's medical record.

5.7.2 Facilities must reserve a therapeutically absent recipient's bed and are prohibited from deriving any Medicaid revenue for that recipient other than the reimbursement for the bed during the period of absence. Facilities are reimbursed at their full current Medicaid bed rate for a bed reserved due to therapeutic leave. Facilities are not reimbursed for therapeutic-leave days which exceed the legal limit.

5.7.3 Therapeutic leave is not applicable when the leave is for the purpose of receiving either inpatient or nursing services provided either elsewhere or at a different level of care in the facility of current residence, when such services are or will be paid for by Medicaid. Transportation from a facility to the site of therapeutic leave is not considered an emergency. Therefore, ambulance service for this purpose is not reimbursed by Medicaid.

5.7.4 ICF/MR group homes can take residents on vacation within the requirements/rules of the Medicaid program. The time away from the group home is not considered therapeutic leave. Each individual program plan must identify specific goals/objectives to be met during the vacation. Sufficient facility staff must accompany residents to assure that all their personal and training needs are met.

6.0 Providers Eligible to Bill the Service

ICF/MR providers enrolled in the N.C. Medicaid program who provide this service may bill for these services.

7.0 Additional Requirements

7.1 Recipient Recertification

In all private and state-owned ICF/MR facilities and group homes, a utilization review by a committee must occur for each recipient at least every 180 days in order to decide whether ICF/MR level of care is needed, according to the criteria in **Section 3.2**. If the committee determines that the recipient continues to meet the ICF/MR criteria the recipient is recertified for ICF/MR level of care. A medical doctor must document the initial certification. The physician, physician assistant, or nurse practitioner may document subsequent recertification. The physician is responsible for co-signing and dating all recertifications written by the nurse practitioner or physician assistant.

7.2 Facility Recertification

The Division of Facility Services conducts recertification surveys to determine if the ICF/MR facility complies with the federal requirements for the Condition of Active Treatment (CFR: 483.440). If the facility fails to comply with the requirement for active treatment of a Medicaid recipient, the Division of Facility Services notifies the Medicaid program of a change in the recipient's level of care from ICF/MR.

7.3 Comprehensive Functional Assessment

7.3.1 Within 30 days after a recipient is admitted to an ICF/MR facility, the Interdisciplinary Team must perform an accurate comprehensive functional assessment.

7.3.2 The comprehensive functional assessment of each recipient must be reviewed annually by the Interdisciplinary Team for relevancy and updated as needed.

7.4 Individual Program Plan

7.4.1 Within 30 days after a recipient is admitted to an ICF/MR facility, the Interdisciplinary Team must prepare for each client an individual program plan (IPP). The IPP must include:

1. specific objectives necessary to meet the recipient's needs as identified by the comprehensive functional assessment;
2. the planned sequence for dealing with these objectives;
3. objectives stated separately in terms of a single behavioral outcome;
    a. objectives with assigned projected completion dates;
    b. objectives expressed in behavioral terms that provide measurable indices of performance;
    c. objectives that are organized to reflect a developmental progression appropriate to the individual recipient;
4. a description of relevant interventions to support the individual toward independence.
5. the location where program strategy information can be found.
6. for recipients who lack them, training in personal skills essential for privacy and independence, until it has been demonstrated that the client is developmentally incapable of acquiring them.

7. identification of mechanical supports, if needed
   a. the reason for each support;
   b. the situation in which each is to be applied; **and**
   c. a schedule for the use of each support.

7.4.2 Individual Program Plan Review

1. The individual program plan must be reviewed at least by the qualified professional (QP) and revised as necessary.
2. The individual program plan must be reviewed at least annually.

8.0 Policy Implementation/Revision Information

Original Effective Date: June 1, 1991

Revision Information:

Date	Section Revised	Change
8/1/06	Attachment A	Billing information related to the date of admission and date of discharge was added to the Billing Guidelines.

Attachment A: Claims Related Information

Reimbursement requires compliance with all Medicaid guidelines including obtaining appropriate referrals for recipients enrolled in Medicaid Managed Care programs.

A. Claim Type

ICF/MR providers enrolled in the N.C. Medicaid program bill services on the UB-92 claim form.

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis that most accurately describes the reason for the encounter. Diagnostic codes(s) to the highest level of specificity that supports medical necessity.

C. Procedure Code(s)

Providers bill using ICF/MR per diem code RC100. Therapeutic leave is billed using RC183.

D. Billing Unit

Billing is at a per diem rate.

E. Place of Service

ICF/MR services are provided in Intermediate Care Facilities.

F. Reimbursement

Providers must bill usual and customary charges. Reimbursement is at a per diem rate that is all inclusive except for medical and dental services.

Medicaid reimbursement to nursing facilities and intermediate care facilities is based on the facility's midnight census. Because payment can only be paid to one facility for each day of care, the date of admission is counted as the first day the patient occupies a bed at the midnight census.

The date of discharge is counted as the last day the patient occupies a bed at the midnight census. The discharge date is not considered a day of patient care and is not billable to Medicaid. This also applies to the date of death when it occurs prior to the midnight census. The date of death is not considered a day of patient care and is not billable to Medicaid. The only exception to this procedure is if the date of admission and the date of discharge (or the date of death) occur on the same day.

G. Copyament

Recipients that reside in an ICF/MR are excluded from copayments.

Attachment B: Functional Limitations As Defined By Developmental Disabilities Act

The federal government has defined developmental disabilities as disabilities that are chronic and attributable to mental and/or physical impairments, which are evident prior to age twenty-two. Such disabilities tend to be lifelong and result in substantial limitations in three or more of the following major life activities:

- Self Care: Daily activities that enable a person to meet basic life needs for eating, hygiene, grooming, health and personal safety. A substantial limitation occurs when a person needs assistance at least one-half the time for one activity, or needs some assistance in more than one-half of all activities normally required for self-care. Assistance is usually in the form of the intervention of another person directly or indirectly by prompts, reminding and/or supervising someone.
- Receptive and Expressive Language: Communication involving both verbal and nonverbal behaviors that enable the person both to understand others and to express ideas and information to others. The concept of language includes reading, writing, listening and speaking as well as the cognitive skills necessary for receptive language. A substantial limitation occurs when a person is unable to effectively communicate with another person without the aid of a third person, a person with a special skill, or a mechanical device, or is unable to articulate thoughts and/or to make ideas and wants known.
- Learning: General cognitive competence and ability to acquire new behaviors, perceptions and information and to apply previous experience in new situations. When a person requires special intervention or special programs to assist that person in learning a substantial limitation occurs. Children who meet the eligibility standard for infant/toddler or special education services or need significant special interventions such as assistive devices or special testing procedures in regular education programs in order to learn would have a functional limitation in learning.
- Mobility: Motor development and ability to use fine and gross motor skills. A substantial limitation occurs when the ability to use motor skills requires assistance of another person and/or a mechanical device in order for the person to perform age appropriate skills in two skill areas, or to move from place to place inside and/or outside the home.
- Self-Direction: Ability to make independent decisions regarding and to manage and control one's social and individual activities and/or in handling personal finances and or protecting one's own self interest. A substantial functional limitation occurs when a child is unable, at an age appropriate level, to make decisions and exercise judgment, behave in a socially acceptable manner, and/or act in his/her own interest. An adult may require direct or indirect assistance such as supervision by another person or counseling to successfully utilize these skills.
- Capacity for Independent Living: Maintain a full and varied life in one's own home and community. A child who is unable, at an age appropriate level, to assist with household chores, maintain appropriate roles and relationships with the family, use money, and/or use community resources has a substantial functional limitation in this are. The child requires more assistance to perform these activities than a typical child of the same chronological age. An adult displays a significant functional limitation when he/she requires assistance in the activities more than half the time.